Partnerships in Care Limited

Kneesworth House

Inspection report

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This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this location	Inspected but not rated
Are services safe?	Inspected but not rated
Are services effective?	Inspected but not rated
Are services well-led?	Inspected but not rated

Summary of findings

Overall summary

We carried out this unannounced focused inspection because we received information giving us concerns about the safety and quality of the service.

We inspected specific safe, effective and well-led key questions for the service.

We did not rate this service at this inspection. The previous rating of good overall with requires improvement for safe, good for effective, caring, responsive and well led remains.

The report for the previous inspection can be found here:

https://www.cqc.org.uk/location/1-129389215/reports

We found the following areas of good practice:

- Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery.
- The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service.
- Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care. Managers gave each new member of staff a full induction to the service before they started work.
- Staff provided a range of treatment and care for patients based on national guidance and best practice.
- Governance processes operated effectively at team level and performance and risk were managed well.

However, we found the following areas the provider needs to improve:

- Staff did not always update risk assessments following incidents, although they were recorded in the clinical notes and discussed by the multidisciplinary team.
- The seclusion room environment did not meet the requirements set out in the Mental Health Act Code of Practice.

Summary of findings

Our judgements about each of the main services

Service	Rating	Summary of each main service
Forensic inpatient or secure wards	Inspected but not rated	

Summary of findings

Contents

Summary of this inspection

Background to Kneesworth House

Kneesworth House is operated by Partnerships in Care which is part of the Priory Group of companies and is situated in Cambridgeshire, close to the Hertfordshire border. It provides inpatient care for people with acute mental health problems, a psychiatric intensive care unit, locked and open rehabilitation services, and medium and low secure forensic services for people with enduring mental health problems.

The service is registered to provide the following regulated activities:

- Assessment or medical treatment for persons detained under the Mental Health Act 1983
- Treatment of disease, disorder or injury
- Diagnostic and screening procedures

We inspected the following service:

Forensic inpatient/secure wards

- Clopton - 12 bed medium secure service for men with a personality disorder.
- Ermine - 19 bed medium secure service for men with a mental illness.

How we carried out this inspection

1. During the inspection visit, the inspection team:

- visited two wards at the hospital and looked at the quality of the ward environments;
- Met with the Priory Healthcare's senior management team:
- spoke with the registered manager, clinical service directors and one ward manager;
- spoke with six other staff members; including nursing staff, psychologist, training facilitator and security co-ordinator;
- spoke with two patients;
- looked at six care and treatment records of patients:
- looked at 12 seclusion records;
- looked at a range of policies, procedures and other documents relating to the running of the service.

You can find information about how we carry out our inspections on our website: https://www.cqc.org.uk/what-we-do/how-we-do-our-job/what-we-do-inspection.

Areas for improvement

Action the service MUST take is necessary to comply with its legal obligations. Action a trust SHOULD take is because it was not doing something required by a regulation but it would be disproportionate to find a breach of the regulation overall, to prevent it failing to comply with legal requirements in future, or to improve services.

Action the service MUST take to improve:

Summary of this inspection

- The service must ensure that seclusion room environments meet the criteria set out by the Mental Health Act Code of Practice.
- The service must ensure that patients are searched before being placed into seclusion.
- The service must ensure that risk assessments are updated following incidents.

Our findings

Overview of ratings

Our ratings for this location are:

	Safe	Effective	Caring	Responsive	Well-led	Overall
Forensic inpatient or secure wards	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated
Overall	Inspected but not rated	Inspected but not rated	Not inspected	Not inspected	Inspected but not rated	Inspected but not rated

Inspected but not rated

Forensic inpatient or secure wards

Safe	Inspected but not rated
Effective	Inspected but not rated
Well-led	Inspected but not rated

Are Forensic inpatient or secure wards safe?

Inspected but not rated

We did not rate the service at this inspection and our previous rating of requires improvement remains.

Safe and clean care environments

All wards were safe, clean well equipped, well furnished, well maintained and fit for purpose.

Maintenance, cleanliness and infection control

Ward areas were clean, well maintained, well furnished and fit for purpose. We visited Clopton and Ermine wards and found that all areas including patient bedrooms were visibly clean and well maintained.

Staff made sure cleaning records were up-to-date and the premises were clean. Housekeeping staff cleaned the ward areas including patient bedrooms daily and staff encouraged patients to keep the areas clean and tidy for the rest of the day. The provider used a rating system to identify which patients required support with keeping their bedrooms clean and tidy. Staff included plans to support patients with keeping bedrooms clean and tidy in their care plans.

Staff followed infection control policy, including handwashing. We observed that the provider had taken appropriate actions in response to the Covid-19 pandemic to mitigate the risk of infection to patients and staff.

Seclusion room

The Seclusion rooms allowed clear observation and two-way communication. They had a toilet and a clock. However, the seclusion rooms both contained alarm covers that could be removed by a patient and used to harm themselves or others. One seclusion room also had beading on top of the en-suite door frame that was not securely fixed in places and the seal around the viewing window was loose, and these could be used by a patient to harm themselves. We raised this with the provider during the inspection and this room was decommissioned from use until these issues could be rectified.

Assessing and managing risk to patients and staff

Staff assessed and managed risks to patients and themselves well. They achieved the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. Staff had the skills to develop and implement good positive behaviour support plans and followed best practice in anticipating, de-escalating and managing challenging behaviour. As a result, they used restraint and seclusion only after attempts at de-escalation had failed. The ward staff participated in the provider's restrictive interventions reduction programme.

Inspected but not rated

Forensic inpatient or secure wards

Assessment of patient risk

Risk assessments did not always reflect current risk. Staff completed risk assessments for each patient on admission, using a recognised tool, and reviewed this regularly, however staff did not always update these after an incident. We looked at five patient records and found that staff recorded incidents in clinical notes and these had been reviewed by the multi-disciplinary team but they did not update the risk assessment document. We saw examples of where patients had been involved in violent incidents and whilst staff had documented this in their patient record and risk formulation, the risk screen documented their risk of violence as low.

Management of patient risk

Staff knew about any risks to each patient and acted to prevent or reduce risks. We looked at five patient records and saw that staff documented risks and incidents in the clinical notes. However, as the risk assessment document was not always updated new staff could not easily identify the current risk level for patients.

Staff identified and responded to any changes in risks to, or posed by, patients.

Staff followed procedures to minimise risks where they could not easily observe patients.

Where clinical observations where required to manage a patient's risk these had been decided upon at the multidisciplinary team meeting and had been conducted appropriately.

Staff followed hospital policies and procedures when they needed to search patients or their equipment or bedrooms to keep them safe from harm. Where patients had restricted access to equipment based on their risk, this was managed through care plans and there were clear written agreements for patients to follow.

Patients did not have access to public wireless internet access on the wards. Access to the internet and smart mobile phones was managed on an individual risk assessed basis and under supervision. There was appropriate monitoring in place to ensure any concerns were identified and investigated.

The secure service had an appropriate process in place for the management of post. Patients opened their post in front of staff and where restricted items were received by patients, access to these was managed on a risk assessed basis.

Use of restrictive interventions

Levels of restrictive interventions were low.

Staff participated in the provider's restrictive interventions reduction programme, which met best practice standards.

Staff made every attempt to avoid using restraint by using de-escalation techniques and restrained patients only when these failed and when necessary to keep the patient or others safe.

When a patient was placed in seclusion, staff kept records of the seclusion but did not always follow best practice guidelines.

The service recorded 17 incidents of seclusion between March and August 2021 with nine on Clopton Ward and eight on Ermine Ward. We looked at 12 incidents of seclusion relating to eight patients and found that in 11 of these the patient had a medical review within an hour of seclusion and in all cases patients had medical reviews every four hours until their multi-disciplinary review.

We saw that there were significant improvements in seclusion care plans since the last inspection. Care plans were detailed and individualised, containing aspects of the patients' positive behaviour support plans. However, the care plan for one patient remained the same for three incidents of seclusion and it was not clear whether staff had reviewed it.

The 15-minute observation records showed patients' requests for food and drink, heating, blankets, lights, telephone calls, takeaway meals were met or if it was not possible then the reasons for this were clearly stated. Patients could access the courtyard for fresh air and were offered activities including access to television and games consoles whilst in seclusion.

Seclusion records were audited but we found the following that required some improvement: Patients were not routinely searched prior to seclusion and seclusion records did not state what items a patient had taken into the room. It was usual that one of the staff involved in the decision to seclude the patient was part of the first nursing review.

Track record on safety

The service had a good track record on safety.

Reporting incidents and learning from when things go wrong

The service managed patient safety incidents well. Staff recognised incidents and reported them appropriately. Managers investigated incidents and shared lessons learned with the whole team and the wider service. When things went wrong, staff apologised and gave patients honest information and suitable support.

Staff knew what incidents to report and how to report them.

Staff raised concerns and reported incidents and near misses in line with provider policy.

Staff reported serious incidents clearly and in line with provider policy. The provider used an electronic incident reporting system. We looked at eight serious incidents that had been identified as a cause for concern prior to the inspection. Staff had recorded the incidents using the electronic system, and managers had completed investigations for incidents that met the serious incident threshold.

The service had no never events on any wards.

Staff understood the duty of candour. They were open and transparent and gave patients and families a full explanation if and when things went wrong.

Managers debriefed and supported staff after any serious incident. Managers completed a staff welfare check following any incident.

Managers investigated incidents thoroughly. The provider reported any serious incidents that required further investigation to the police and local authority safeguarding team. We saw evidence of when police and safeguarding investigations had taken place. We reviewed two incidents where patients were alleged to have circumvented security protocols and found that this had been escalated to the police for investigation and appropriate action taken. Managers had notified CQC appropriately regarding relevant incidents of concern. One incident was noted where the hospital had not fully informed the Ministry of Justice of concerns about a restricted patient. However, we did not find any other concerns that had not been reported appropriately.

Inspected but not rated

Forensic inpatient or secure wards

Managers discussed incidents in the daily morning meeting and added investigations or action required to an action plan until completed.

Staff received feedback from investigation of incidents, both internal and external to the service.

Staff met to discuss the feedback and look at improvements to patient care.

Are Forensic inpatient or secure wards effective?

Inspected but not rated

We did not rate the service at this inspection and our previous rating of good remains.

Best practice in treatment and care

Staff provided a range of treatment and care for patients based on national guidance and best practice. They ensured that patients had good access to physical healthcare and supported them to live healthier lives. Staff used recognised rating scales to assess and record severity and outcomes. They also participated in clinical audit, benchmarking and quality improvement initiatives.

Staff provided a range of care and treatment suitable for the patients in the service. The service offered a range of therapeutic activities including one to one psychology sessions for all patients; psychology informed group sessions such as mindfulness; occupational therapy sessions such as cooking and physical health; and some patients were able to access paid vocational work where risk levels allowed.

Skilled staff to deliver care

The ward teams included or had access to the full range of specialists required to meet the needs of patients on the wards. Managers made sure they had staff with the range of skills needed to provide high quality care. They supported staff with appraisals, supervision and opportunities to update and further develop their skills. Managers provided an induction programme for new staff.

The service had access to a full range of specialists to meet the needs of the patients on the ward.

Managers ensured staff had the right skills, qualifications and experience to meet the needs of the patients in their care, including bank and agency staff.

Managers gave each new member of staff a full induction to the service before they started work. The provider had a two-week induction programme in place that all new staff completed prior to working on a ward. This included security training, observation practice and seclusion engagement, search training and Safe wards training sessions. New staff members completed an induction folder that included competency checks by their manager and their probationary period was only signed off once all competency checks were completed. New staff also undertook additional online learning throughout their probationary period. Staff were allocated a mentor on the ward to support them through their probationary period. New staff who required additional support to complete their competency checks were offered additional training. We saw that new staff received appropriate supervision in line with provider policy.

Inspected but not rated

Forensic inpatient or secure wards

Good practice in applying the Mental Capacity Act

Staff supported patients to make decisions on their care for themselves. They understood the trust policy on the Mental Capacity Act 2005 and assessed and recorded capacity clearly for patients who might have impaired mental capacity.

Staff gave patients all possible support to make specific decisions for themselves before deciding a patient did not have the capacity to do so.

When staff assessed patients as not having capacity, they made decisions in the best interest of patients and considered the patient's wishes, feelings, culture and history.

Are Forensic inpatient or secure wards well-led?

Inspected but not rated

We did not rate the service at this inspection and our previous rating of good remains.

Culture

Staff felt respected, supported and valued.

The provider's management team had worked to address previous concerns around restrictive practice and to achieve the right balance between maintaining safety and providing the least restrictive environment possible to support patients' recovery. The provider continued to work on embedding this balance in staff culture and had commenced a potential closed culture review.

The provider's management team had implemented a range of activities to support staff regarding any concerns that they had about their work. A welfare action plan was in place and activities to support this included access to freedom to speak up guardians and a counselling provider, staff support sessions and engagement work with female employees.

Governance

Our findings from the other key questions demonstrated that governance processes operated effectively at team level and that performance and risk were managed well.

The provider had policies and procedures in place to manage the safety of the hospital. We reviewed 10 policies and procedures including the use of mobile telephones and technology; banned and restricted items; searching of patients; and the withholding of mail procedure. The provider had robust processes around information technology safety, but the provider recognised that there was additional training required to ensure these were embedded in staff culture.

The provider had a site improvement plan in place at the time of the inspection. The provider had also created an action plan to address the concerns raised by whistleblowers, that included an independent review of cyber security updated policies for searching of patient mobile telephones, and a refresher course on maintaining boundaries for all staff working on the wards.

Management of risk, issues and performance

Teams had access to the information they needed to provide safe and effective care and used that information to good effect.

Inspected but not rated

Forensic inpatient or secure wards

The provider had a clear structure for overseeing performance, quality and risk. Senior and ward managers met every morning to discuss ward issues including risks and review incident reports. Managers then added incidents requiring investigation to an action log until the investigations had been completed.

Clinical governance meetings had a clear framework and included review of incidents and risks.

We reviewed eight serious incidents that had been investigated by managers and had been raised with the local safeguarding team and police where appropriate.

The provider had a policy on the use of mobile telephones and technology by patients and all patients' access to technology was risk assessed. Patients with high risks had additional agreements in place for technology use developed with the local police force and social workers.

This section is primarily information for the provider

Requirement notices

Action we have told the provider to take

The table below shows the legal requirements that were not being met. The provider must send CQC a report that says what action they are going to take to meet these requirements.

Regulated activity	Regulation
Assessment or medical treatment for persons detained under the Mental Health Act 1983 Treatment of disease, disorder or injury	Regulation 12 HSCA (RA) Regulations 2014 Safe care and treatment • Risk assessments were not always updated following incidents • The seclusion room did not meet the Mental Health Act Code of Practice